State of Vermont
Department of Financial Regulation
89 Main Street
Montpelier, VT 05620-3101
www.dfr.vt.gov

MEMORANDUM

To: Green Mountain Care Board

From: Susan L. Donegan
Commissioner, Department of Financial Regulation

Date: December 5, 2013

Re: Recommendation for Approval of TVHP First and Second Quarter 2014 Trend Filing (SERFF Tracking No. BCVT-129197313)

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1. Introduction

The Green Mountain Care Board (GMCB or Board) was created by Act 48 of the Vermont Legislature in 2011 to oversee a broad range of health care reforms in Vermont, including the eventual transition to a publicly-financed single payer system known as Green Mountain Care. The reforms mandated by Act 48 are designed to increase Vermonters' access to quality health care services while at the same time containing the rapid rise of health care costs. Although Act 48 will be implemented in coordination with the federal Affordable Care Act, its reforms go significantly beyond those required by federal law, particularly in the areas of payment reform and cost containment.

Through the end of 2013, rate filings for major medical health insurance policies will be reviewed by the Commissioner of Financial Regulation. If the Commissioner finds that the proposed rate satisfies the applicable statutory requirements (see "Standard of Review" below) the Commissioner is required to recommend approval of the rate to the GMCB. The Commissioner can also recommend that the GMCB modify or disapprove the rate. This represents a change from prior statutory procedure, which gave the Commissioner sole discretion to approve or disapprove health insurance rate filings. Once the Board has acted on the Commissioner's recommendation, the Commissioner is responsible for implementing the Board's decision.

2. Brief Description of Company and Filing

The Vermont Health Plan (TVHP) is a licensed health maintenance organization (HMO) and for-profit subsidiary of BlueCross BlueShield of Vermont (BCBSVT) that provides HMO, point of service (POS), and Medicare supplement coverage to approximately 41,200 Vermonters. The company offers a variety of plans and products in the group market in Vermont.

The present filing is not a premium rate filing but rather a trend filing that sets forth the percentage by which TVHP expects its per capita twelve-month medical and prescription drug costs to increase for large group policyholders who enroll or renew coverage during the first and second quarters of 2014.[1] Medical claims, administrative expenses, and contributions to surplus are the major components of TVHP's premium rate filings and the company currently files its medical trends for approval on a semi-annual basis. TVHP's first and second quarter 2014 trends, if approved, will be applied as a multiplier to the medical and pharmacy claims component of the company's existing rates in order to determine the price that will be charged for each medical and pharmacy product renewed or sold in the large group market during the first and second quarters of 2014. Based on the most recent enrollment figures, the proposed trends will affect approximately 11,600 TVHP members in the large group market, plus any new business acquired during the first and second quarters.

3. Standard of Review

Section 5104(a)(2) of Title 8 V.S.A. provides that rates submitted by a health maintenance organization such as the Vermont Health Plan must not be "excessive, inadequate or unfairly discriminatory or fail to meet the standards of affordability, promotion of quality care, and promotion of access pursuant to section 4062 of this title." This standard is also applicable to major components of a rate filing such as the medical trend.

The terms "excessive," "inadequate" and "unfairly discriminatory" each have well-accepted definitions that are codified in the insurance laws of most states. Thus, rates are generally considered excessive if they are likely to produce unreasonably high profits for the insurance provided or if expenses are unreasonably high in relation to the services rendered. Rates are considered inadequate if they are insufficient to sustain projected losses and expenses in the class of business to which they apply. Finally, rates are unfairly discriminatory if price differentials for groups of insureds fail to reflect equitably the differences in projected losses and expenses for those groups.

For the purpose of applying the statutory criteria set forth in 8 V.S.A. § 4062, the Insurance Division has adopted the following definitions.

[1] The large group market is for employers with more than 50 employees and the small group market is for employers with 50 or fewer employees. After January 1, 2014, insureds in the individual and small group markets will begin purchasing their health insurance through the online health benefit exchange (Vermont Health Connect) mandated by the federal Affordable Care Act.

A. Affordable: A rate change (or a trend factor change) is affordable, if:

1. The overall proposed increase is less than 10.0% higher than the previously approved overall change; and

2. Following review, the rate or trend factor change is found to be actuarially justified.

3. A proposed rate or trend factor increase of ten percent or greater over the previously approved change is presumptively not affordable, unless, following review, the department finds that the proposed increase is actuarially justified and is necessary to sustain projected losses and necessary expenses for the class of business in question.

B. Promotes quality care: The Department does not supervise providers. In the context of rate regulation, a rate or trend factor, whether new or a proposed change, promotes quality care if the policy forms with which the rate or trend factor will be used have been filed with and approved by the Department. Department approval of the policy forms means that all health care benefits mandated by Vermont law have been provided.

C. Promotes access to health care: A rate or trend factor, whether new or a proposed change, promotes access to health care if it is affordable, as defined above, and if the policy forms with which the rate or trend factor will be associated provide consumers an opportunity to seek an independent review of adverse coverage determinations.

4. <u>Analysis and Recommendation</u>

a. <u>Summary of Department Analysis:</u>

TVHP's first and second quarter 2014 trend filing was submitted to the Department on September 10, 2013 and was deemed complete, following review by the Department's contract actuary, Oliver Wyman, on November 21, 2013. In this filing, TVHP is proposing trend factors of 4.1% for medical claims, 7.2% for pharmaceutical claims, and 4.6% for combined medical and prescription drug claims. This represents a reduction from TVHP's approved 3Q/4Q13 trend factors were 4.6% for medical claims, 8.1% for pharmacy claims and 5.3% for medical and pharmaceutical claims combined.

In calculating the proposed medical trend, TVHP used claims for the period from June 2010 through May 2013 as the starting point (i.e., the base experience).[2] Claims in excess of $120,000 were

[2] TVHP performed separate trend calculations for its high deductible health plans (HDHPs) and its non-high deductible plans (non-HDHPs) and then blended the two results based on the percentage of its insured population

removed from the underlying experience to ensure that cost trends occurring during the base period were not skewed upward or downward by any unusually large claims. TVHP then analyzed cost growth during the base experience period using a variety of statistical methodologies. The proposed 4.1% trend reflects the anticipated cost growth produced by these methodologies for claims below the $120,000 level (plus 3.6%), adjusted upward to reflect an estimate of what will be needed to cover large claims during the new rating period.[3]

TVHP's proposed prescription drug trend was based on incurred pharmaceutical claims from January 1, 2010 to June 30, 2013. TVHP calculated the trend using both its own large group claims experience as well as the large group claims data of its corporate parent, BlueCross BlueShield of Vermont (BCBSVT). Oliver Wyman found it reasonable to combine the experience of the two companies since both use the same prescription drug reimbursement schedules. (Opinion at 3). TVHP's proposed pharmaceutical trend is 0.9% lower than its approved 3Q/4Q13 trend, and would have been even lower but for the company's assumption that the significant growth during the past few years in the use of less costly generic drugs will moderate during the first two quarters of 2014. Oliver Wyman found this assumption, which was based on TVHP's review of historical utilization trends and of which drugs will be coming off patent in the new rating period, to be reasonable. (Opinion at 7).

Using the same base experience periods as TVHP, Oliver Wyman independently calculated the 1Q14 and 2Q14 trend factors and determined that a reasonable range for the medical trend would be 4.0%-5.2% and that a reasonable range for the pharmaceutical trend would be 5.3%-9.5%. TVHP's proposed medical trend of 4.1% falls at the low end of Oliver Wyman's independently-calculated range of reasonableness, while the proposed pharmaceutical trend of 7.2% falls within the middle of that range.[4] Oliver Wyman concluded that both trends are actuarially reasonable and should produce rates that are not excessive, deficient or unfairly discriminatory.

In addition to TVHP's first and second quarter trend factors, the filing also sets forth the deductible leveraging and stop loss dampened factors that will be used to adjust the proposed trends to take account of the specific cost sharing and risk spreading features of each plan. Deductible leveraging

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in each type of plan. The reason for separating HDHP and non-HDHP claims is that the two types of plans have different utilization patterns, which can, in turn, affect the trends for each type of plan.

[3] It should be noted that while the proposed trend will be used primarily in calculating the rates for large groups, the claims data underlying the trend is derived not only from large group experience, but also from small group and individual experience as well. While the use of a larger data pool enhances the statistical reliability of the resulting trend in this filing, Oliver Wyman cautions that in future filings TVHP may need to revisit the appropriateness of incorporating small group and individual claims data in the large group trend calculation. This is because once consumers in the individual and small group markets migrate to the health benefits exchange mandated by the ACA, their claims experience and utilization may be affected by benefits, cost-sharing designs and subsidies that are not available in the large group market.

[4] TVHP's proposed medical trend of 4.1% is well below the 25th percentile of nationwide HMO trends (6.2%), based on a survey of 66 national health care carriers covering 108 million lives conducted by Oliver Wyman in mid-2013. TVHP's proposed pharmaceutical trend of 7.2% falls at approximately the 25th percentile (7.0%) of nationwide trends in the same survey.

occurs when a policy's deductible remains the same over a period of time but medical costs rise. This has the effect of increasing the percentage of each claim that is born by the insurer, and is compensated for during the rate development process by making an upward adjustment in the approved medical and pharmaceutical trends. Since the leveraging effect is more pronounced in high deductible plans (where the insurer's cost share is lower), the needed adjustment becomes greater as a plan's deductible increases. The deductible leveraging factor table (Exhibit IV in the filing) sets forth the specific adjustments that will be made to TVHP's proposed trends depending on a plan's deductible and co-insurance.

Stop loss dampened factors, on the other hand, are used to adjust trends to take account of a plan's stop loss attachment point. Insurers often purchase stop loss insurance as a way of mitigating the risk of unexpectedly high claims. The attachment point is the dollar threshold in a stop loss policy at which contractual responsibility for paying claims shifts from the primary insurer to the stop loss insurer. As the attachment point rises and the primary insurer assumes greater responsibility for paying claims, the effect of medical inflation on the primary insurer's claims costs becomes greater, thus necessitating an upward adjustment in the trend factors applied in the rate development. The stop loss dampened factors in the filing (also Exhibit IV) represent the specific adjustments that will be made to the proposed trend depending on a particular plan's stop loss attachment point.

Oliver Wyman identified no issues with TVHP's proposed 1Q14 and 2Q14 leveraging and stop loss dampened factors.

b. Commissioner's Recommendation:

The Commissioner recommends that the GMCB approve TVHP's 1Q/2Q14 trend factors as filed. The Department's actuary has found that the proposed trends are actuarially reasonable and fall within the low to middle range of Oliver Wyman's independently calculated range of reasonable trends. Moreover, as noted above (see footnote 4), both trends are in the bottom quartile of countrywide trends.

TVHP is required to maintain certain minimum surplus levels set by the Department and the national Blue Cross BlueShield association. Maintenance of adequate surplus is a critical consumer protection, particularly for entities that are not members of an insurance guaranty association. In evaluating the current financial position of TVHP, the Director of Company Licensing and Examinations has reviewed current surplus levels, the potential impact of past rate decisions not yet in effect and the uncertainty due to market and regulatory changes. Given these factors, he cautions that reducing trends in a manner that increases the company's exposure to unexpected adverse events is not advisable at this time.

/s/ Susan L. Donegan
Susan L. Donegan, Commissioner

SUPPLEMENTAL INFORMATION

1. Insurance Company's Plain Language Summary

As required by 8 V.S.A. §4062(c) the submission of this filing included a plain language summary. The plain language summary is included as an addendum to this report and marked as Attachment 1.

2. General Information Pertaining to Rate or Trend Filing

1. Company: The Vermont Health Plan.
2. Title of Rate Filing: Trend factor filing for first and second quarter of 2014.
3. Rate Proposal: The company is requesting the following: (a) a 4.1% medical trend; (b) 7.2% prescription trend; and (c) a 4.6% combined medical and prescription drug trend.
    a. New Rate: No.
    b. Rate Change: Yes.
4. Range of Proposed Rate Change: Not applicable.
5. # of Policies Impacted: Not provided.
6. # of Covered Lives Impacted: 11,600.

3. Filing Information

1. Date of Submission: 09/10/2013.
2. Date Assigned to Rate Analyst: 09/10/2013.
3. Date Filing Deemed Complete: 11/21/2013.
4. Date Filing Posted on Dept. website: Not applicable.
5. Date Ending Public Comment: Not applicable.

4. Financial Information

Information from TVHP's Restated Underwriting Results Exhibit for June 2012 through May 2013 is set forth in the non-redacted version of Oliver Wyman's actuarial analysis for this rate filing.

5. Actuarial Review

The rate filing was reviewed by the Department of Financial Regulation's contracted actuary. The actuary's opinion is included as an addendum to this report and marked as Attachment 2.

6. Public Comment

The filing was not subject to public comment.